DCH/LDN-503 (01/04)

Michigan Department of Community Health
Board of Dentistry
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918

DENTAL RELICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Dentistry. Questions regarding your application can be directed to the Michigan Board of Dentistry at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, the applicant's signature and date will be returned.

GENERAL INSTRUCTIONS FOR RELICENSURE

1. Type or print legibly on all forms and send original application, with the proper fee, to the Board of Dentistry. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application and fee are no longer valid.

2. Complete the relicensure application and return it with the appropriate fee and proof of current CPR certification and the required continuing education.

   Dentist- Proof of Current Certification in basic or advanced life support AND evidence of completion of 60 hours of continuing education acceptable to the board during the three year period immediately preceding the date of this application.

   Dental Hygiene- Proof of Current Certification in basic or advanced life support AND evidence of completion of 36 hours of continuing education acceptable to the board during the three year period immediately preceding the date of this application, with 12 of the 36 hours devoted to registered dental hygienist functions.

   Dental Assistant- Proof of Current Certification in basic or advanced life support AND evidence of 36 hours of continuing education acceptable to the board during the three year period immediately preceding the date of this application, with 12 of the 36 hours devoted to registered dental assistant functions.

3. Verification of license/registration must be sent directly to this office from each state that you hold or have ever held a license/registration in.

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE GOOD FOR A THREE-YEAR PERIOD.

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APPLICATION FOR RELICENSURE

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Print or Type Only

I AM APPLYING FOR THE FOLLOWING:

- ❒ Dentist Relicensure - Fee: $140.00 71-2901-06
- ❒ Registered Dental Assistant Relicensure Fee: $50.00 71-2903-06
- ❒ Registered Dental Hygienist Relicensure Fee: $65.00 71-2902-06

Board Use Only
License Number
Date of Licensure

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date
Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Has your Michigan dental license been lapsed more than three years?

❒ Yes ❒ No

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	❒ Yes	❒ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	❒ Yes	❒ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	❒ Yes	❒ No
4. Have you been treated for substance abuse in the past 2 years?	❒ Yes	❒ No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	❒ Yes	❒ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	❒ Yes	❒ No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

7. Have you ever had a federal or state license or registration revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you? ❒ Yes ❒ No

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ❒ Yes ❒ No

List the state(s) in which you hold or have ever held a license or registration for your profession, the license number, the date issued, and how the license was obtained (either endorsement or examination). DO NOT LIST TEMPORARY LICENSE. **You must have each state board verify licensure or registration directly to this board office. (Attach additional sheets if necessary.)**

State	License/Registration Number	Date of Issue	How obtained (Endorsement or examination)

Check appropriate box and submit the required information for relicensure.

☐ **DENTIST**- Proof of current certification in basic or advanced life support AND evidence of completion of 60 hours of continuing education acceptable to the board during the three year period immediately preceding the date of this application.

☐ **REGISTERED DENTAL HYGIENIST** - Proof of current certification in basic or advanced life support AND evidence of completion of 36 hours of continuing education acceptable to the board during the three year period immediately preceding the date of this application, with 12 of the 36 hours devoted to registered dental hygienist functions.

☐ **REGISTERED DENTAL ASSISTANT** - Proof of current certification in basic or advanced life support AND evidence of completion of 36 hours of continuing education acceptable to the board during the three year period immediately preceding the date of this application, with 12 of the 36 hours devoted to registered dental assistant functions.

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-090 (03/05)

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you only prescribe controlled substances at more than one location, you only need one controlled substance license.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.

Board Use Only
License Number
Date of Licensure

Type or Print Only

INSTRUCTIONS

1. CONTROLLED SUBSTANCE FEE: **Initial (first time) professional license or relicensure of your professional license - $85.00. If you already hold a professional license and your professional license expires in:**

0-12 months the fee is $85.00 (13757) **13-24 months the fee is $160.00 (23757)** **25-36 months the fee is $235.00 (33757)**

2. **M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.**

3. **Allow up to six weeks for your paper license to arrive.**

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

THIS LICENSE VALID - ONLY AT THE FOLLOWING LOCATION

Street	Telephone Number

City	State	ZIP Code

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

	Regular		Educational Limited
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐
☐ 43 - 01 M.D. 71-5315	☐		
☐ 51 - 01 D.O. 71-5315	☐		
☐ 49 - 01 O.D. 71-5330	☐		
☐ 53 - 01 Pharmacy Store 71-5301	☐		
☐ 53 - 02 R.Ph. 71-5302	☐		
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐		

STATUS:

1. **Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**

☐ **Yes** ☐ **No**

If Yes, please explain on separate sheet.

2. **Is your current professional license limited as a result of Board disciplinary action?**

☐ **Yes** ☐ **No**

Michigan Permanent I.D. Number (as shown on your pocket card)	
Expiration Date of License	Social Security Number

I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.

Signature	Date

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.